Referral for Latent Tuberculosis Infection Treatment

1) *To be completed by Civil Surgeons*
   - Complete if patient has a **positive IGRA** and ruled out for active TB
   - Please attach the results of both the IGRA and CXR and complete the section below

Dear ____,

I am referring _________________________________(DOB:_______________) to your care for the treatment of **latent tuberculosis infection** (LTBI). I evaluated the patient as part of immigration screening requirements. I am referring the patient to you because the patient had a **positive IGRA** and was ruled out for active/infectious TB. To prevent TB disease from developing, **treatment** for LTBI is recommended in most patients. See cdph.ca.gov/ltbitreatment for more information.

Below and attached please find a summary of the patient's evaluation. **When the patient completes treatment or has another outcome, please fax this form to the local health department TB program (see CTCA.org for contact info).**

Chest x-ray result: ☐normal ☐ abnormal, not consistent with TB (see report attached)
Interferon-gamma release assay: see report attached

Additional comments: ____

______________________________	___________________	________________________	_________
Signature/Civil Surgeon Name	Phone number	E-mail	Date

---

2) *To be completed by Receiving Provider:*

LTBI Treatment

☐ Date started treatment: _________________

☐ Date completed treatment: ______________
with the following regimen:
- ☐ Isoniazid/Rifapentine (3 months; 3HP)
- ☐ Rifampin (4 months; 4R)
- ☐ Isoniazid (9 months; 9H)
- ☐ Isoniazid (6 months; 6H)
- ☐ Other:_________________________

If patient did ***not*** start treatment, primary reason why:
- ☐ Lost to follow-up
- ☐ Treatment medically contraindicated
- ☐ Patient refused
- ☐ Other: ___________________

If patient started but did ***not*** complete treatment, primary reason why:
- ☐ Patient chose to stop
- ☐ Provider chose to stop
- ☐ Pregnancy
- ☐ Patient moved
- ☐ Lost to follow-up
- ☐ Active TB developed
- ☐ Adverse event related to treatment
- ☐ Patient died
- ☐ Other: ___________________

______________________________	___________________	________________________	_________
Signature/Provider Name	Phone number	E-mail	Date

Fax to the local health department TB program once complete
(see CTCA.org for contact info)

September 2018